DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 0 0 — 0 1 2

2. STATE: Ohio

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
August 16, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
CFR Part 441-Subpart C; CFR Part 441-Subpart D;
CFR Part 447-Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ (10,999,999)
b. FFY 2001 $ (19,000,001)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Pages 13-~~30~~ 28 of Attachment 4.19A,
Rules 5101:3-2-09 and 5101:3-2-10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Pages 13-~~22~~ 30 of Attachment 4.19-A,
Rules 5101:3-2-09 and 5101:3-2-10

10. SUBJECT OF AMENDMENT:

Disproportionate share and indigent care adjustments for general hospitals and psychiatric hospitals.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

Governor has delegated review to ODJFS Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Jacqueline Romer-Sensky

13. TYPED NAME:
Jacqueline Romer-Sensky

14. TITLE:
Director

15. DATE SUBMITTED:
August 30, 2000

16. RETURN TO:

Ohio Department of Job and Family Services
30 E. Broad Street, 27th Floor
Columbus, OH 43266-0423

Attention: Becky Jackson
Bureau of Health Plan Policy

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:
9/11/00

18. DATE APPROVED:
11/16/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 16, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Cheryl A. Harris

22. TITLE:
Associate Regional Administrator
Division of Medicaid and Insurance Oversight

23. REMARKS:

RECEIVED
SEP 11 2000
DMO - IL/IN/OH

FORM HCFA-179 (07-92)

*Instructions on Back*

Disproportionate Share and Indigent Care for General Hospitals

This Section applies to all general hospitals eligible to participate in Medicaid who do not meet the criteria in paragraphs (B), (C) and (D) of Rule 5101:3-2-01.

(A) SOURCE DATA FOR CALCULATIONS

The calculations described for determining disproportionate share hospitals and in making disproportionate share and indigent care payments will be based on data provided in annual cost reports submitted to the department under the provisions of Rule 5101:3-2-23 ~~and data reported by the health care financing administration (HCFA) on Medicare days and SSI days~~. The cost reports used will be for the hospital's cost reporting period ending in state fiscal year **1999**. If specific program data is not available from these reports, the otherwise most recent, reviewed, cost report information will be used. The HCFA data used will be as reported by HCFA for federal fiscal year **1998**.

(B) DETERMINATION OF DISPROPORTIONATE SHARE HOSPITALS

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify (including Children's and DRG exempt hospitals) are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

(1) Have a Medicaid utilization rate greater than or equal to one percent.

(2) Have a low income utilization rate in excess of 25 percent, where low income utilization rate is:

$$\frac{\text{Medicaid payments + Cash subsidies for patient services received directly from state and local government}}{\text{Total hospital revenues (including cash subsidies for patient services received directly from state and local governments)}}$$

+

$$\frac{\text{Total charges for inpatient services for charity care}}{\text{Total charges for inpatient services}}$$

(3) Have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid, except that:

(i) The provisions of (3) do not apply to hospitals the inpatients of which are predominantly individuals under 18 years of age; or

(ii) The provisions of (3) do not apply if the hospital does not offer non-emergency obstetric services to the general population as of December 22, 1987; or

(iii) In the case of hospitals located in a rural area (as defined for purposes of Section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

Hospitals that do not qualify for a disproportionate share adjustment receive additional payments in the form of an indigent care adjustment.

(C) DISPROPORTIONATE SHARE AND INDIGENT CARE POOL

The disproportionate share and indigent care pool are created in compliance with the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 and the regulations issued in the August 13, 1993 Federal Register. Furthermore, it is an assurance of this plan that the amount of payments made to disproportionate share hospitals will not exceed, in the aggregate, the limits prescribed under subparagraph (f)(2)(A) of Section 1923.

(D) DISPROPORTIONATE SHARE AND INDIGENT CARE PAYMENTS

~~For purposes of distributing disproportionate share and indigent care payments, NINE groups of hospitals have been developed. The overall pool described in (C) above is distributed among the NINE hospital groups based on each group's historic share in the provision of statewide indigent care.~~

(E) DISTRIBUTION FORMULAS FOR INDIGENT CARE PAYMENT POOLS.

(1) Hospitals meeting the high federal disproportionate share hospital definition, are eligible to receive funds from the high federal disproportionate share indigent care payment pool. A high federal disproportionate share hospital is defined as one whose ratio of total Medicaid days and Medicaid MCP days to total days is greater than the statewide mean ratio of total Medicaid days and Medicaid MCP days to total days plus one standard deviation. Funds are distributed to hospitals which meet this definition ~~within each hospital care assurance grouping~~ according to the following formula.

(a) For each hospital that meets the definition of high disproportionate share ~~in each of the hospital care assurance groups~~, calculate the ratio of the hospital's total Medicaid costs and total Medicaid MCP costs to the sum of total Medicaid costs and medicaid MCP costs for all hospitals ~~in each hospital care assurance group that have hospitals~~ which meet the definition of high federal disproportionate share described in paragraph (E)(1).

(b) For each hospital ~~in the hospital care assurance groups~~, multiply the ratio calculated in paragraph (E)(1)(a) by THIRTY MILLION DOLLARS. THIS IS THE hospital's federal high disproportionate share hospital payment amount.

(2) Hospitals ~~within the hospital care assurance groups~~ are eligible to receive funds from the Medicaid indigent care payment pool according to the following formulas.

(a) For each hospital ~~within a hospital care assurance group who meets the requirements of paragraph (E)(2)~~, calculate Medicaid shortfall by subtracting from total Medicaid costs total Medicaid payments. For hospitals with a negative Medicaid shortfall, the Medicaid shortfall amount is equal to zero.

(b) For each hospital ~~within the hospital care assurance group~~, sum the hospital's Medicaid shortfall, total Medicaid costs, total Medicaid MCP costs, and total Title V costs.

(c) For all hospitals ~~within the hospital care assurance group~~, sum all hospitals Medicaid shortfall, total Medicaid costs, Total Medicaid MCP costs, and total Title V costs.

(d) For each hospital ~~within the hospital care assurance group~~, calculate the ratio of the amount in paragraph (E)(2)(b) to the amount in paragraph (E)(2)(c).

(e) For each hospital ~~within the hospital care assurance group~~, multiply the ratio calculated in paragraph (E)(2)(d) by **$90,810,067** to determine each hospital's Medicaid indigent care payment amount.

(3) Hospitals ~~within the hospital care assurance groups~~ are eligible to receive funds from the disability assistance medical and uncompensated care ~~under one hundred percent~~ indigent care payment pool.

(a) FOR EACH HOSPITAL, MULTIPLY A FACTOR OF 0.30 BY THE HOSPITAL'S TOTAL UNCOMPENSATED CARE COSTS ABOVE ONE HUNDRED PERCENT WITHOUT INSURANCE.

(b) For each hospital ~~within the hospital care assurance group~~, sum total disability assistance medical costs and total uncompensated care costs under

one hundred per cent, AND THE AMOUNT CALCULATED IN PARAGRAPH (E)(3)(a).

(c) For all hospitals ~~within the hospital care assurance group~~, sum total disability assistance medical costs, total uncompensated care costs under one hundred per cent, AND THE AMOUNTS CALCULATED IN PARAGRAPH (E)(3)(a).

(d) For each hospital ~~within the hospital care assurance group~~, calculate the ratio of the amount in paragraph (E)(3)(b) to the amount in paragraph (E)(3)(c).

(e) For each hospital ~~within the hospital care assurance group~~, multiply the ratio calculated in paragraph (E)(3)(d) by THREE HUNDRED TEN MILLION DOLLARS to determine each hospital's disability assistance medical and uncompensated care ~~under one hundred per cent~~ indigent care payment amount.

(F) DISTRIBUTION OF FUNDS THROUGH THE DISPROPORTIONATE SHARE LIMIT POOL.

(1) FOR EACH HOSPITAL, CALCULATE THE HOSPITAL'S SPECIFIC DISPROPORTIONATE SHARE LIMIT AS DEFINED IN PARAGRAPH (II).

(2) FOR EACH HOSPITAL, SUM THE HOSPITAL'S TOTAL PAYMENTS ALLOCATED IN PARAGRAPHS (E)(1)(b), (E)(2)(e), AND (E)(3)(e).

(3) MULTIPLY EACH HOSPITAL'S ADJUSTED TOTAL FACILITY COSTS THAT ARE LESS THAN OR EQUAL TO $217,252,765 BY 0.018. FOR HOSPITALS WITH ADJUSTED TOTAL FACILITY COSTS THAT ARE GREATER THAN $217,252,765, MULTIPLY A FACTOR OF 0.01 TIMES THE HOSPITAL'S ADJUSTED TOTAL FACILITY COSTS THAT ARE IN EXCESS OF $217,252,765. FOR EACH HOSPITAL, MULTIPLY A FACTOR OF 0.50 BY THE AMOUNT CALCULATED.

(4) FOR EACH HOSPITAL, SUM THE AMOUNTS CALCULATED IN PARAGRAPHS (F)(2) AND (F)(3).

(5) FUNDS IN THE DISPROPORTIONATE SHARE LIMIT POOL WILL BE DISTRIBUTED AS DESCRIBED IN PARAGRAPHS (F)(5)(a) TO (F)(5)(c).

(a) FOR EACH HOSPITAL, IF THE AMOUNT CALCULATED IN PARAGRAPH (F)(2) IS GREATER THAN THE AMOUNT CALCULATED IN (F)(1), THE HOSPITAL WILL RECEIVE NO PAYMENT FROM THE DISPROPORTIONATE SHARE LIMIT POOL.

(b) FOR EACH HOSPITAL, IF THE AMOUNT CALCULATED IN PARAGRAPH (F)(4) IS LESS THAN THE AMOUNT CALCULATED IN PARAGRAPH (F)(1), THE AMOUNT IN PARAGRAPH (F)(3) WILL BE THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT POOL PAYMENT AMOUNT.

(c) FOR EACH HOSPITAL, IF THE AMOUNT CALCULATED IN PARAGRAPH (F)(4) IS GREATER THAN THE AMOUNT CALCULATED IN PARAGRAPH (F)(1) AND THE AMOUNT CALCULATED IN PARAGRAPH (F)(2) IS LESS THAN THE AMOUNT CALCULATED IN PARAGRAPH (F)(1), THEN THE HOSPITAL'S DISPROPORTIONATE SHARE LIMIT POOL PAYMENT AMOUNT WILL BE THE DIFFERENCE BETWEEN THE AMOUNTS IN PARAGRAPHS (F)(1) AND (F)(2).

(G) DISTRIBUTION MODEL ADJUSTMENTS AND LIMITATIONS THROUGH THE STATEWIDE RESIDUAL POOL.

(1) For each hospital, subtract the hospital's specific disproportionate share limit as defined in paragraph (H) from the payment amount as calculated in paragraphs (F)(2) and (F)(5) to determine if a hospital's calculated payment amount is greater than its disproportionate share limit.

If a hospital's calculated payment amount is greater than its disproportionate share limit, then the hospital's payment is equal to the hospital's disproportionate share limit. The portion of the calculated amount above the disproportionate share limit, referred to as residual payment funds, is subtracted from the hospital's calculated payment amount and is applied to ~~the hospital care assurance group residual pool and~~ the statewide residual payment pool as described in paragraph (G)(2).

(2) RE-DISTRIBUTION OF RESIDUAL PAYMENT FUNDS IN THE STATEWIDE RESIDUAL PAYMENT POOL.

(a) FOR EACH HOSPITAL WITH A CALCULATED PAYMENT AMOUNT THAT IS NOT GREATER THAN THE DISPROPORTIONATE SHARE LIMIT, AS DESCRIBED IN PARAGRAPH (H), SUBTRACT THE PAYMENT AMOUNT DESCRIBED IN PARAGRAPH (G)(1) FROM THE AMOUNT OF THE DISPROPORTIONATE SHARE LIMIT.

(b) FOR ALL HOSPITALS WITH CALCULATED PAYMENT AMOUNTS THAT ARE NOT GREATER THAN THE DISPROPORTIONATE SHARE LIMIT, SUM THE AMOUNTS CALCULATED IN PARAGRAPH (G)(2)(a) OF THIS RULE.

5101:3-2-08 Assessment policies for disproportionate share and indigent care adjustments for hospital services.



The provisions of this rule are applicable for the program year that ends in calendar year 2000 ~~1999~~ for all medicaid-participating providers of hospital services included in the definition of "hospital" as described in paragraph (A)(3) of this rule.



(A) Definitions.

(1) "Disproportionate share hospital" means a hospital which meets criteria for disproportionate share status as defined in rule 5101:3-2-075 of the Administrative Code.

(2) "Governmental hospital" means a county hospital with more than five hundred beds or a state-owned and -operated hospital with more than five hundred beds.

(3) "Hospital" means a hospital which is described under section 5112.01 of the Revised Code.

(4) "Hospital care assurance program fund" means the fund described under section 5112.18 of the Revised Code.

(5) "Hospital care assurance match fund" means the fund described under section 5112.18 of the Revised Code.

(6) "Intergovernmental transfer" means any transfer of money by a governmental hospital.

(7) "Legislative budget services fund" means the fund described under section 5112.19 of the Revised Code.

(8) "Medical assistance program" means the program of medical assistance established under section 5111.01 of the Revised Code and under Title XIX of the Social Security Act, 49 stat. 620 (1935), 42 U.S.C. 301, as amended.

(9) "Program year" means the twelve-month period beginning on the first day of October and ending on the thirtieth day of September.

(10) "Total facility costs" for each hospital means the amount from the ODHS 2930, schedule B, column 3, line 101.

(11) "Total skilled nursing facility costs" for each hospital means the amount on the ODHS 2930, schedule B, column 3, line 34.

(12) "Total home health facility costs" for each hospital means the amount on the ODHS 2930, schedule B, column 3, line 67.

(13) "Other non-hospital costs" for each hospital means separately identifiable non-hospital operating costs found on worksheet B, Part I of the medicare cost report, as determined by the department upon the request of the hospital, that are permitted to be excluded from the provider tax in compliance with section 1903 (w) of the Social Security Act.

(B) Applicability.

The requirements of this rule apply as long as the United States health care financing administration determines that the assessment imposed under section 5112.06 of the Revised Code is a permissible health care related tax pursuant to section 1903(w) of the Social Security Act, 49 stat 620 (1935), 42 U.S.C.A. 1396b(W), as amended. Whenever the department of human services is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance fund that has been paid by the hospital, plus any investment earnings on that amount.

(C) Source data for calculations.

The calculations described in this rule will be based on cost-reporting data described in rule 5101:3-2-23 of the Administrative Code which reflect the hospital's cost reporting period ending in state fiscal year 1999 ~~1998~~.

For new hospitals, the first available cost report filed with the department in accordance with rule 5101:3-2-23 of the Administrative Code will be used until a cost report which meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available. For hospitals which have changed ownership, the cost reporting data filed by the previous owner which reflects that hospital's cost reporting period ending in state fiscal year 1999 ~~1998~~ will be used. Cost reports for hospitals involved in mergers during the program year that result in the hospitals using one provider number will be combined and annualized by the department to reflect one full year of operation. For hospitals that close during the program year, no cost report data will be used.

Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph and are subject to any adjustments made upon departmental review which is completed each year and subject to the provisions of paragraphs (G) to (G)(4) of this rule.

(D) Calculation of assessment amounts.

The source data described in paragraph (C) of this rule will be the data used in calculating assessment amounts as described in paragraphs (D)(1) to (D)(3) of this rule.

(1) Determine each hospital's total facility costs for services provided to all patients. Subtract from each hospital's total facility cost the hospital's total skilled nursing facility costs the hospital's total home health facility costs, and other non-hospital costs as determined by the department. The difference will be the hospital's adjusted total facility costs.

(2) For hospitals with adjusted total facility cost, as described in paragraph (D)(1) of this rule, that are less than or equal to $217,252,765 ~~$214,904,302~~, multiply the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule by 0.018 ~~0.02~~. The product will be each hospital's assessment amount. For hospitals with adjusted total facility costs, as described in paragraph (D)(1) of this rule, that are greater than $217,252,765

~~$214,904,302~~, multiply a factor of 0.018 ~~0.02~~ times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, up to $217,252,765 ~~$214,904,302~~. Multiply a factor of 0.01 times the hospital's adjusted total facility costs as described in paragraph (D)(1) of this rule, that are in excess of $217,252,765 ~~$214,904,302~~. The sum of the two products will be each hospital's assessment amount.

(3) The assessment amounts calculated in paragraph (D)(2) of this rule are subject to adjustment under the provisions of paragraphs (G) to (G)(4) of this rule.

(E) Determination of intergovernmental transfer amounts.

The department of human services may require governmental hospitals to make intergovernmental transfers each program year.

The department shall notify each governmental hospital of the amount of the intergovernmental transfer it is required to make during the program year.

Each governmental hospital shall make intergovernmental transfers in periodic installments, executed by electronic funds transfer.

(F) Deposits into the legislative budget services fund.

From the first installment of the assessments paid under paragraph (D) of this rule and intergovernmental transfers made under paragraph (E) of this rule during each program year beginning in an odd-numbered calendar year, the department shall deposit into the state treasury to the credit of the legislative budget services fund a total amount equal to the amount by which the biennial appropriation from that fund exceeds the amount of the unexpended, unencumbered monies in that fund.

(G) Notification and reconsideration procedures.

The department will conduct the notification and reconsideration procedures described in paragraphs (G)(1) to (G)(4) of this rule.

(1) The department shall mail by certified mail, return receipt requested, the results of the determinations made under paragraph (D)(3) of this rule to each hospital. If no hospital submits a request for reconsideration as described in this rule, the preliminary determinations constitute the final reconciliation of the amounts that each hospital must pay under this rule.

(2) Not later than fourteen days after the department mails the preliminary determinations as described in paragraph (D)(3) of this rule; any hospital may submit to the department a written request for reconsideration of the preliminary determination made under paragraph (D)(3) of this rule. The request must be accompanied by written materials setting forth the basis for the reconsideration.

If one or more hospitals submit such a request, the department shall hold a public hearing in Columbus, Ohio not later than thirty days after the preliminary determinations have been mailed by the department for the purpose of reconsidering its preliminary determinations. The department shall mail written notice of the date, time, and place of the hearing to every hospital at least ten days before the date of the hearing.

On the basis of the evidence submitted to the department or presented at the public hearing, the department shall reconsider and may adjust the preliminary determinations. The result of the reconsideration is the final reconciliation of the amounts that each hospital must pay under the provisions of this rule.

(3) The department shall mail each hospital written notice of the amount it must pay under the final reconciliation as soon as practical. Any hospital may appeal the amount it must pay to the court of common pleas of Franklin county.

(4) In the course of any program year, the department may adjust the assessment rate defined in paragraph (D)(2) of this rule or adjust the amount of the intergovernmental transfers required under paragraph (E) of this rule, and, as a result of the adjustment , adjust each hospital's assessment and intergovernmental transfer, to reflect refinements made by the United States health care financing administration during that program year to the limits prescribed under subparagraph (f) of section 1923 of the Social Security Act, 42 U.S.C.A. 1396R-4(f), as amended.

(5) Finalization of data

(a) The department may ~~shall~~ mail any data the department may choose to use for disproportionate share and indigent care adjustments, described in rule 5101:3-2-09 of the Administrative Code to each hospital. Not later than fourteen days after the department mails the data, any hospital may submit to the department a written request to correct data. Any documents, data, or other information that supports the hospital's request to correct data must be submitted with the request. On the basis of the information submitted to the department, the department may adjust the data.

~~(b) For the program year that ends in calendar year 1999, the department may notify hospitals of an extended opportunity to submit a written request to correct data. Not later than seven days after the department mails the data, any hospital may submit to the department a written request to correct data. Any documents, data, or other information that supports the hospital's request to correct data must be submitted with the request. On the basis of the information submitted to the department, the department may adjust the data and will then consider all data final.~~

(H) Confidentiality.

Except as specifically required by the provisions of this rule and rule 5101:3-2-24 of the Administrative Code, information filed shall not include any patient-identifying material. Information including patient-identifying information is not a public record under section 149.43 of

the Revised Code and no patient-identifying material shall be released publicly by the department of human services or by any person under contract with the department who has access to such information.

Effective Date: 28 SEPT 2000

Rule Review Dates: August 26, 1999, August 26, 2004

Certification:

18 SEPT 2000
Date

Promulgated under Chapter 119.

Statutory Authority RC Section 5112.03

Rule Amplifies RC Chapter 5112.

Prior Effective Date: 7/1/94, 2/27/95 (Emer.), 5/18/95, 6/26/96 (Emer.), 8/13/96, 7/24/97 (Emer.), 8/21/97 (Emer.), 11/1/97, 6/26/98 (Emer.), 9/1/98, 4/16/99 (Emer.), 6/10/99 (Emer.), 7/16/00 (Emer.), 8/26/99, 7/14/00 (Emer.)

(c) FOR EACH HOSPITAL WITH A CALCULATED PAYMENT AMOUNT THAT IS NOT GREATER THAN THE DISPROPORTIONATE SHARE LIMIT, DETERMINE THE RATIO OF THE AMOUNTS IN PARAGRAPH (G)(2)(a) AND (G)(2)(b).

(d) FOR EACH HOSPITAL WITH A CALCULATED PAYMENT AMOUNT THAT IS NOT GREATER THAN THE DISPROPORTIONATE SHARE LIMIT, MULTIPLY THE RATIO CALCULATED IN PARAGRAPH (G)(2)(c) OF THIS RULE BY THE TOTAL AMOUNT DISTRIBUTED THROUGH THE STATEWIDE RESIDUAL POOL DESCRIBED IN PARAGRAPH (G)(1). THIS AMOUNT IS THE HOSPITAL'S STATEWIDE RESIDUAL PAYMENT POOL PAYMENT AMOUNT.

(H) LIMITATIONS ON DISPROPORTIONATE SHARE AND INDIGENT CARE PAYMENTS MADE TO HOSPITALS

(1) For each hospital calculate Medicaid shortfall by subtracting from total Medicaid costs. For hospitals exempt from the prospective payment system, Medicaid shortfall equals zero.

(2) For each hospital, calculate total inpatient costs for patients without insurance by multiplying the hospitals' inpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for inpatient disability assistance medical, inpatient uncompensated care under one hundred per cent, and inpatient uncompensated care above one hundred per cent.

(3) For each hospital, calculate total outpatient costs for patients without insurance by multiplying the hospitals' outpatient Medicaid cost-to-charge ratio, by the sum of hospital's reported charges for outpatient disability assistance medical, outpatient uncompensated care under one hundred per cent, and outpatient uncompensated care above one hundred per cent.

(4) FOR EACH HOSPITAL, CALCULATE MEDICAID OUTPATIENT RADIOLOGY SERVICES SHORTFALL AS DESCRIBED IN PARAGRAPHS (H)(4)(a) TO (H)(4)(e).

(a) Using the Medicaid claims payment system as the source of data, determine total charges for outpatient radiology procedures, for each hospital, for the time period corresponding to each hospital's fiscal year ending in state fiscal year **1999**.

(b) Using the Medicaid claims payment system as the source of data, determine total payments for outpatient radiology procedures, for each hospital, for the time period corresponding to each hospital's fiscal year ending in state fiscal year **1999**.

(c) For each hospital, calculate the hospital specific outpatient cost to charge ratio by dividing total medicaid outpatient costs by total medicaid outpatient charges.

(d) For each hospital, determine total medicaid outpatient radiology costs by multiplying the ratio calculated in paragraph (H)(4)(c) by the amount in paragraph (H)(4)(a) .

(e) For each hospital, total medicaid outpatient radiology shortfall is equal to the amount in paragraph (H)(4)(d) minus the amount in (H)(4)(b).

(5) For each hospital, calculate the hospital disproportionate share limit by adding the Medicaid shortfall as described in paragraph (H)(1), inpatient uncompensated care as described in paragraph (H)(2), outpatient uncompensated care as described in paragraph (H)(3), and outpatient radiology shortfall as described in paragraph (H)(4)(e).

(6) The hospital will receive the lessor of the disproportionate share limit as described in paragraph (H)(5) or the disproportionate share and indigent care payment as calculated in paragraphs (E), (F), and (G).

Payments are made to each hospital in installments based on the amount calculated for the annual period. The annual period used in performing disproportionate share/indigent care adjustments is the hospital's fiscal year ending state fiscal year **1999**. Payments are subject to reconciliation if errors have been made in calculating the amount of disproportionate share or indigent care adjustments or if adjustments must be made in order to comply with the federal regulations issued under H.R. 3595.

Expenses associated with payment of hospital assessments are allowable as a Medicaid cost for cost reporting purposes.

Disproportionate share and indigent care payment policies for psychiatric hospitals

This section applies to hospitals eligible to participate in Medicaid only for the provision of inpatient psychiatric services to eligible recipients:

1. Age 65 and older; and
2. Under age 21, or if the recipient was receiving services immediately before he/she reached age 21, services are covered until the earlier of the date he/she no longer requires the services or the date he/she reaches age 22.

The payment policies described below are in accordance with rule 5101:3-2-10. Hospitals eligible to participate only for the provision of inpatient psychiatric services are limited, in accordance with rule 5101:3-2-01, to psychiatric hospitals, and certain alcohol and drug abuse rehabilitation hospitals, that are certified by Medicare for reimbursement of services and are licensed by the Ohio Department of Mental Health or operated under the state mental health authority.

A. Source data for calculations

The calculations described in determining disproportionate share psychiatric and certain alcohol and drug abuse rehabilitation hospitals (hospitals) and in making disproportionate share and indigent care payments will be based on financial data and patient care data for psychiatric inpatient services provided for the hospital fiscal year ending in state fiscal year **1999**.

B. Determination of disproportionate share hospitals

The department makes additional payments to hospitals that qualify for a disproportionate share adjustment. Hospitals that qualify are those that meet at least one of the criteria described under (1) and (2) below, and that also meet the criteria described under (3) below:

(1) The hospital's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for all hospitals receiving Medicaid payments in the state.

The Medicaid inpatient utilization rate is the ratio of the hospital's number of inpatient days attributable to patients who were eligible for medical assistance and who are age twenty-one and under or age sixty-five and older, divided by the hospitals total inpatient days.

(2) The hospital's low-income utilization rate is in excess of twenty-five percent.

The low-income utilization rate is the sum of:

(a) The sum of total Medicaid revenues for inpatient services and cash subsidies for inpatient services received directly from state and local governments, divided by the sum of total facility inpatient revenues and cash subsidies for